MENTAL HEALTH SERVICES ACT (MHSA)
Stakeholders Meeting
December 17, 2004

Attachment 4 – Session #2
Group Feedback

Number of Groups: 48

Participants: about 400	#
State Agency	32
County Agency	84
Local Mental Health Board	33
Legislative	4
Judicial	0
Law Enforcement/Probation	11
Mental Health Provider	84
Mental Health Consumer	67
Family Member of Adult Consumer	53
Family Member of Children/Youth Consumer	27
Organized Labor	12
Advocate Group or Individual	73
Other Statewide Organization	33
Other	27

Feedback was provided by participants at each table to the question below. The responses are grouped together and the number of similar responses are totaled in parentheses.

What should the MHSA Statewide Stakeholder Input Process look like?

Communication Methods (61)

Teleconferencing/Web (13)

- Teleconferencing
- Series of teleconferences
- Virtual regional workshops via teleconferencing for all stakeholder groups; cuts travel expenses and meeting expenses
- Not only town hall meetings, but do meetings through different technologies so individual who cannot come to big meetings still have access
- Need a mechanism to share ideas regarding development in each of the six areas of the MHSA. Some counties may not be well-informed about the possibilities – teleconferences and regional meetings

- DMH has questions on internet so that counties place forms in clinics, all facilities, general community, to provide input
- Regional meetings would be supplemented by the posting of information on the DMH website, teleconferences, CNMHS contract to meet with consumer groups
- Email input – good idea – Develop an interactive email distribution list
- Web-based broadcast, on-line forums, chat rooms, list-servs
- Website is a very good way to get feedback. Spanish translation important, at least, possibly other languages as well
- Website and webcast
- Use web-based communication (chat rooms, bulletin boards, etc.). We can use library computers

Outreach/Multiple Methods (8)

- Do outreach to underserved population
- Hold a Mental Health Services Act Day within each county, to help to pull in underserved populations – provide information on county services that are available while getting information from those individuals who haven't been reached. Information and individuals from this process can be submitted to counties, then to the State
- Every county should be directed by the DMH to go out to the places where potential clients live (board and care facilities, homeless shelters, schools, churches, clubhouses or drop-in centers, coffee houses, food banks, under bridges, in parks, wherever the need is found) with specific information and questions, in the languages of the people, to achieve inclusion on the planning process
- Process is very quick for a lot of people. It should be a grassroots level. This should be an aggressive campaign for all communities. Community meetings are a good venue, as are using the media, neighborhood newspapers, etc.
- State DMH and counties should develop a concrete community outreach program that focuses on reaching clients and front line service providers who know where the real gaps in services and access to care are, and receive their feedback. Such a plan should include PSAs (multilingual) and web portals (multi-lingual) and field staff to reach communities which are typically underserved
- Multiple mechanisms should be employed
- Surveys, invite more community (youth), innovative outreach to "unknown consumers" for more input – we see the "same old same old" clients representing the whole of consumers
- Collect multiple rounds of information from a large group of participants to ensure broad feedback (not just from a few folks) on an ongoing basis

Media/Marketing (7)

- Use of media to get the word out
- Go to the advertising world and see how they target specific communities (use the MSA money) – find a firm with experience reaching ethnic communities – social marketing firms – and get them to do stakeholder process (like the no smoking ads – they are great)
- Satellite broadcast to several areas

- Broadcast on TV public access
- Use the California Channel to broadcast it live
- Advanced marketing or publicity
- Media Campaign with NAMI

Local Meetings/Community Events (7)
- Create a statewide discussion chair (i.e., a coffee day at Starbucks to discuss this issue, contact "to do a statewide PR campaign")
- Create ways to gather information from unknown or unidentified stakeholders, using community forums, client forums, education and outreach, non-English speakers
- Public meetings
- On a local level, public meetings sponsored by Mental Health Boards can be held with PowerPoint presentations, video, handouts, etc. and feedback forms to be collected at the end of the meeting. These will be processed and sent to the state providing information about the input process
- Use advocacy organizations to hold focus groups and report back to larger state stakeholder meetings
- You need to go to each region at least one to get the best input because many rural counties cannot come south or far distances
- Partner with other organizations on the local level that can facilitate and co-host public input meetings

Telephone/800 Number (5)
- State DMH set-up an 800 number and website access to local contacts
- Consider holding "open door forums" – CMS has a nationwide phone-in monthly program. Their website has information if it is a good model to obtain stakeholder input
- There should be an 800 number for clients who can't contribute any other way, plus adaptive services
- Telephone trees
- DMH should have a fax line people can use to submit comments in any language

Use Existing Outlets (5)
- Use well-equipped UC and CSU campuses and well-equipped counties
- Community college (sociology class project) to gather input
- Public school announcements
- Go to health centers, schools, pharmacies, etc. with information
- Put information in utility bills, post office boxes (develop MHSA logo for people to begin to recognize) – could also be used as anti-stigma

Surveys (4)
- Get input from surveys and "think outside the box" models for access
- Use survey and questionnaires
- No canned surveys – a true dialogue

- Use field surveys establishing a set list of targeted groups (even if some counties lack some groups)

Statewide Events (4)
- Need some statewide process of this group and some smaller groups on a regular basis.
- Initial monthly meeting in Sacramento until end of spring
- Incorporate some statewide meetings, perhaps parallel to break-out and plenary sessions at a single conference
- Formalized linkage to other State agencies

Regular Mail (2)
- Mail out to stakeholders – not just the website
- Not everyone knows how to use, some do not have internet access; handouts should be mailed by snail mail upon request

Other (6)
- Letter to Boards of Supervisors about how money is to be used
- Printed information and announcements using layman's terms, in all languages used within community
- Opportunity to submit detailed written comments
- Use a facilitator to ask questions (will help filter inappropriate questions)
- Ensure strategic plan includes reaching out to all stakeholders (some don't have websites)
- Celebrity spokesperson (rock star status)

Process (41)

Meeting Process (10)
- The model used for this meeting should be replicated
- Stay with large group so everyone can hear everything, but have small group time with an issue focus and time to report back to large group
- Need materials in advance
- Give advanced notice for meetings, especially to the underserved
- Circulate attendance from this meeting to all with contact information
- Meetings must have clear expectations and message and overview
- Working lunches would be a good idea for this large meeting
- Develop exact format and questions
- More handouts needed on tables at stakeholder meetings
- No table should be allowed to have all people from the same county at it

Information Dissemination/Coordination (9)
- Disseminate meeting information to general public
- Anticipate client and family mobility and develop county collaboratives and agreements to accommodate

- Data sharing system to handle mobile clients
- Evaluation: hire an evaluator used throughout the process, not only self-assessment, but include an outside evaluation, just like any county initiative, it needs to be understood by all staff members
- Minutes kept, placed on web
- Post statewide and require locally to disseminate input gathered so far; mail minutes (locally) or make available at libraries
- Information gathered from meetings available to all on web and by mail and videotape
- We all receive the same information. Time of day, time of week. Share input the better from stakeholders.

<u>Stakeholder Process Itself (The Whole Process, exclusive of meeting mechanics) (7)</u>

- Sequential or staggered implementation in the system of care, which would results in staggered approval to get off the ground – more flexibility in its implementation finding balance that we are making progress – not caught up in process but execution and content
- Do not add another layer of planning, use current planning structure. Use existing boards and current stakeholders
- Start planning process at local level
- Seek objective point of view from other states (President's Commission)
- Need consistent participation – same people showing up, not revolving door
- Do not feel the meeting topics need to be repeated at the next meeting. Each meeting regardless of its location should build-up on the last
- Input must be in a way that is not intimidating – that is, productive, and is then shared directly to the county without a filter

<u>Funding (6)</u>

- Need to consider child care and elder care funds and provisions for people to participate
- Please release some funds as soon as possible to promote consumer involvement in planning, such as the CNMHC Forum
- Fund individuals to provide their professional input
- We think the planning money should be sent to counties right away, with the directive that this outreach should be done immediately
- If counties don't fulfill guidelines, they shouldn't get money beyond initial allocation of $75,000. Speed is not the issue, slow down and do it right
- Funding should not be based on a county's size, rather on its needs. Larger counties have always had the lion's share of funding, leaving smaller counties short of funds to implement and maintain necessary programs

<u>Goals (5)</u>

- Uniform base of knowledge
- Need to tap into creativity to reform the system – entirely, which may need outside consultants

- Look at exactly how it was set up to be
- Determine underserved populations, staff shortages and training programs
- Make it clear the goal of the process – input to DMH, not decision-making

Timing (4)
- A thorough, slower process is better
- Move along process in a more timely fashion.
- Need to have a closure of this process so we know what are the end results and regular updates on the progress
- Be expedient and concise

Regional Meetings (38)

Regional (17)
- Regional meetings
- Regional meetings would provide input, although we want to implement without the input then be the same old business (that's what it says)
- There needs to be regional focus vs. using a bifurcated system
- Regional meetings for feedback, then get together
- Rotate meeting location for representation of all of California
- Process permitted good initial forum for public and all. Future regional meetings may need crowd control and focus on cross-section of potential consumers, not necessarily for all comers.
- Regional, but should be some groups by area of interest
- Smaller (regional or local) meetings; nice if simultaneous, but understand that staff shortages makes this difficult, yet opportunities with distance learning (video conferences) can make this possible
- Regional/county meetings
- Small regional meetings – already the Mental Health Directors and the QIC are divided by regions. The region idea would work in the same way. For example, northern and southern QICs and small counties coalition vs. the large counties
- Regional, not north/south
- State needs to hold meetings in the regions to inform stakeholders about their role in this process
- Partner with CalNET to co-host public regional meeting throughout the state

North/South (13)
- Divide North and South
- Consideration of conducting stakeholders meeting in the future north and south
- Provide a meeting at least in north and south and find site that will accommodate and bring unrepresented persons to the meeting (homeless, foster care, children and parents, etc.)
- North/South – allowance for travel costs

- Have larger meetings (regional – north and south) which are accessible to local service recipients and provide resources (money) to facilitate their travel and participation. This will build individual ownership and vestiture in the plan
- Regional stakeholder input meetings – north/south/small counties
- North/South meetings would be better than one big one
- At the north/south meetings, have more facilitators available and break into small groups so more people can speak

More than North/South (6)
- Need to look at regional meetings beyond a North/South structure
- No less than three regional meetings
- Recommend dividing the state into 4 area meetings to allow smaller workgroups but not too much delay in implementation
- Include about four regions
- Regional meetings – divide state into five regions, or whatever is standard for DMH
- Determine regional groups – CMHDA – perhaps five regions

Not North/South and Not Regional (2)
- No regional meetings!
- No regional meetings, no north/south meetings either

Consumers & Other Stakeholders (32)

Consumers and Perspective Consumers (12)
- Consumers, families
- Offer scholarships for consumers and other low income participants (a certain number of each county or city)
- Interview consumers – needs assessment
- Funding process for delegates to be nominated to be part of planning process (stipends for people who represent under-represented groups)
- Get youth representation
- Appropriate outreach to homeless population
- Outreach to general community and those already receiving services
- Disabled population
- Stipends for consumers and meals provided to encourage their participation
- State sponsored stakeholders who represent underserved and unserved communities to bring input of community to DMH
- Volunteering participation should not be a pre-condition for Prop. 63 funded services

Other Stakeholders (10)
- The real focus needs to be on how to get to “real appropriate needs,” contact IHSS and other groups who see the invisible, those who are shut in
- Advisory Boards
- Get lawyers, law enforcement officers, and judges involved in the process

- Outreach to human services/health care, the professional associations listed – today it's the usual suspects – that should change this
- Regional DHHS and HUD – need to educate them, bring them in as partners
- Include representatives from physical fitness and nutritional fields, beyond Mental Health members
- Professionals HCA, courts, Probation, providers, police, public, schools, county counsel, physical health care, Public Guardian, public defenders
- Coordinate with other agencies outside of Mental Health, such as housing, Northern California Center on Deafness, ADP, etc.
- Work with other organizations that work with folks that are not identified as "mental health" – communities of color, stakeholders that get you to underserved groups
- Insurance companies need to be invited to be part of the process

<u>Process with Stakeholders (6)</u>
- Get information out to everyone who may be or are stakeholders about discussions (sheriffs, local police, judges, lawyers, governor, representatives, providers, etc.)
- Training and literature and outreach to social services organizations
- Organized groups can also forward isolated groups' comments to the right person
- Take advantage of stakeholder conferences scheduled during next six months, including CASRA, to get information out
- Any limits on number of participants from an individual organization
- Who are the people and groups at the stakeholders meetings, who is being represented?

<u>Advocates/Community-Based Stakeholders (4)</u>
- CIMH could play a role in getting this information out
- Advocacy groups who have written policy process should be involved
- Community-based stakeholders could be involved in brainstorming
- Outreach to schools and community regarding prevention and early intervention, specifically, counseling, nursing and student assistance programs

State Role (20)

<u>Oversight/Standards/Leadership (10)</u>
- State MHSA stakeholder meeting participants as establishing principles
- DMH establish standards for stakeholder training
- DMH should be giving direction and ideas about how to carry out a meaningful stakeholder process. Creative mechanisms to reach underserved and unserved people locally: good ideas need to be shared! DMH should seek out information about what is working well and actively sharing the methods
- State needs to develop clear, outcome-oriented guidelines for local planning and to keep stakeholders informed
- We need to spend more time creating guidelines for the county stakeholder processes – help needed with creative outreach process techniques in the counties
- Hold counties accountable, train folks in how to participate in local planning process

- State's role is to come up with guidelines, put stuff on website, ask advocacy groups and stakeholders for comments
- State has ethnical and moral responsibility to take leadership to include groups that are usually not at the table. First increase the staff at the State Office of Multicultural Services, then fund statewide planning efforts of underserved groups including funding of staff to lead and organize consumers and families
- This process needs to be an effective vehicle for influencing the local county process. Accountability in the resulting documents for counties to abide by the statewide standards developed by this process needs to be established, especially in securing broad and comprehensive input outside the county system. For example, once county plans are submitted for state review: the state reviewers should include an open public comment period, perhaps on-line, so stakeholders can express concerns with the local county process and counties can be held accountable to those concerns
- DMH ensure consumer and family input and participation in state and local planning activities, ensuring diversity in age, gender, language and culture

Coordination (7)
- We need County Mentorship programs: counties that have active stakeholders can assist nearby counties that need more support to create an effective process (e.g., self-help) – would need State to play a role in determining how
- State should ask the counties to distribute MHSA information to isolated groups (in various languages) and provide an opportunity to respond to the materials in various ways (i.e., website, network of care, mailings)
- Need point person region to region with them meeting to ensure consistency of process and dissemination of information and ideas
- DMH translates input to suggested models, ideas, etc. back to counties for plans to begin
- DMH coordinate for stakeholder training
- DMH take lead to determine service needs gaps by collaboration with other state departments to maximize other funding sources and to coordinate with other state planning efforts
- Create Stakeholder Advisory Board – broad-based representation, culturally, ethnically representative, family, consumer, agency, labor bases.

Other (3)
- To provide money to each county and the two city programs to assist the counties to reach the underserved populations to get their input
- Help counties in their efforts to reach out and involve consumers, require co-leadership in local planning
- State provides counties with technical assistance

Diversity (18)

Cultural Competence (5)
- How to move forward cultural competence – State process inclusive

- Cultural competence process should include staff at all levels culturally and linguistically proficient to serve population. There should be a set guideline based on service, time needed to administer service, per target population in a given day. Correspondence of any type (forms, letters, etc.) should be language-specific. Any form of communication should be language specific. As one member stated, "Competency is only being addressed because there is incompetence."
- DMH should recognize the diversity within the communities identified as underserved. "Asians" are a myriad group of communities of different nationalities and cultures (Filipinos, Vietnamese, etc.) and it cannot be assumed these communities lumped together under an umbrella like "Asian American" will share the same experiences and ideas about mental illness, just as they do not share a common language.
- DMH should meet with main stakeholders within each cultural group – hear about how that culture views mental illness, views western medicine, government, law enforcement, doctors, pills, etc. – learn about how their culture heals mental illness, what they need concerning housing, etc.
- To reach underserved or ethnically diverse communities, the approach needs to be from an insider perspective. The use of cultural brokers as facilitators, with state representatives as recorders only (use CBOs)

<u>Language (4)</u>
- Focus groups by threshold languages, facilitated by persons with that language capability
- In terms of diversity, the materials (core materials) need to have translated into Spanish and other threshold languages
- Language competency must be part of the service delivery and stakeholder planning process. Convene stakeholder meetings in the languages spoken by those invited and participating. Language competence includes communication in modalities such as ASL or captioning, for example.
- Outreach to ethnic-specific health care/general primary care – non-English speaking

<u>Inclusivity (3)</u>
- Diversity and all-inclusive
- Inclusive and fair to all stakeholders that it moves process forward in least amount of time
- Make sure the stakeholder process is physically and otherwise accessible to all in selection of meeting sites, etc.

<u>Resources (3)</u>
- Use other cultures' resources (especially media resources) locally
- Find experts in various cultural communities to get people of those communities involved
- Language software such as "Spanish Assistant" for use to allow for translation in electronic messaging and website use

Stakeholder Meetings and Diversity (3)

- There should be ethnic specific focus stakeholder meetings
- Each system of care focused stakeholder meeting to target racial/ethnic communities
- You need to have staff who speak these languages to run focus groups at the stakeholders meetings

Subgroups (18)

Stakeholders (6)

- Focus groups with various entities involved, such as first responders, education, mental health boards and commissions – and what comes out of that goes to a county coordinator or analyst to present to public representatives before it goes to state
- Focus groups for stakeholders
- Subcommittees do outreach to get feedback from specific groups such as business or employers
- Meetings by interest groups (for example, mental health county directors and law enforcement)
- Need to ensure that meetings are held that focus on special topic issues and those stakeholders who have vested interest and expertise would come
- Focus groups by providers (clinicians, special education, education, ministers)

Target Population (4)

- Form stakeholders group for each interested sub-group, e.g. Older adults, transition age youth – and hold meetings in north and south, similar to managed care
- Focus groups by system of care
- Focus groups by age (0-6, 7-12, 13-18, 18-25, 25-55, 55-65, 65+)
- Focus groups by families and consumers at each focus group – consumer driven

Other (8)

- Perhaps each county should hold a meeting to represent a sub-group and those sub-groups report
- Have decentralized focus groups – churches, schools, neighborhood resource centers, shopping centers – where people gather at different times – morning, afternoon, evenings and weekends
- Have meetings with mental health directors and alcohol and drug – maybe two days. Have breakout sub-committees be geographic area or size of counties, age groups, subject matter (i.e., co-occurring disorders)
- Meetings by size of county: small, medium and large counties
- Subgroups
- As a final note, we believe the workplan components should focus on local planning first, followed by capital infrastructure that is critical to ensuring the clients have basic needs met so they can have access to continued stability and access to care. Without housing, without transportation, how will clients be able to access care?
- Need sub-groups based on services

- Develop focus groups (providers, consumers, jails, homeless, ethnic groups, etc.) with Mental Health Board signing off that focus groups are representative (people will talk more freely about needs in small groups)

Components of Plan (13)

- Like the idea of workplan components and have subgroups and meetings for each component
- Like the idea of subgroup meetings, but with staggered times so more can attend
- Like how the components are broad, counties can develop programs according to their unique needs
- Focus groups based on interest or component
- DMH should have at least a daylong meeting (perhaps more than one) on each component of the MHSA because different stakeholders are likely to be involved
- Have the component pieces presented in groups, for example: Capital and innovation; systems of care, etc. in 4 hour timeframes or Day 1: 2 hours on system of care and 2 hours on prevention and Day 2: 2 hours on capital and 2 hours on innovation
- Break into appropriate sub-elements as planning process, example: just infrastructure and break into capital vs. staff/human resources
- Subcommittees by subject – planning, finance, providers
- Each subcommittee should include representatives from key subjects, i.e., planning committee should include a member from finance and local providers, etc.
- Sub-components should have regional meetings to focus on regional needs
- Divide in specific topics
- For innovative programs, use retreat to come up with new ideas rather than business as usual
- Focus groups for innovation (higher institutions focus groups (UC's, CSUs, professionals (Society for Clinical Social Work, CA CASP, CNA, etc.))

County Role (12)

- Every county require their provider agencies to solicit consumer input and forward it to the state, no exceptions
- Every county needs to hear every possible stakeholder and analyze the results
- Counties bring those individuals together and help prepare these people to advocate to the State
- Counties develop stakeholder process
- Stakeholder input should be delegated to the counties
- Counties should be responsible for gathering stakeholders and implementing a process which takes into account diverse community and client needs, diverse provider groups and recognizes cultural/language differences, access to transportation and financial resources for attending meetings
- Local stakeholders look into application and practices
- State can set standards that are federally compliant, but counties are held accountable for their practical execution

- When this information has been gathered, it will be used by each county in its planning process. A summary of the information will be sent to the DMH/MHSA website
- Counties send stakeholder representatives to meetings with the state
- Have representatives from local level go to meetings with state and give feedback
- Neutrality matters – counties may want to hire a consultant to facilitate process

Training (8)

- All new staff need mandatory training on MHSA
- All stakeholders should be educated on the impact of MHSA and shown examples of what it could become – consult national experts on mental health to be part of this stakeholder process
- Develop a training about the feedback process
- Do the training and follow-up with a meeting of the stakeholders
- Provide training and education at stakeholder conferences
- Statewide training for developing plans but not contingent for working and submitting plans
- Regional trainings for counties might help provide them with technical assistance and save on consulting money to help counties develop plans – encourage counties to collaborate on information type meetings to avoid duplication
- Regarding Attachment F, Workplan Components, addition under the fourth bullet include “education from consumers and family members” (who also have a contribution from their perspective – this will complement the workplan, not to negate or supercede the academically educated providers

Best Practices/Dissemination (7)

- Look at different foundations’ methodology for accessing information, such as First 5, The California Wellness Foundation and Sierra Health
- State should serve as a repository for best practices and allow sharing (not re-inventing the wheel)
- The county directors of mental health should meet and share their ideas how to best get their stakeholders involved to the best degree. Los Angeles County has done a very good job and can share their ideas and experience with others and learn from them
- Pooling of the best emerging and promising practices in all counties – sharing information on a website
- Need a way to ensure that “what’s working” is looked at – a place to collect these ideas and make them available
- It might benefit to ask those who implemented Prop 10 and Prop 36 how their input process looked like
- Call upon the experts to present about 2034 programs, consumer-operated programs, campaigns to address discrimination and stigma

Other (4)

- Describe how the Prop 63 funds process will result in system transformation – does the planning process clearly require a new system vision or just focused on use of Prop 63 money?
- Goal to increase conversation statewide and between counties, specifically on special topic issues
- This question is too broad to answer in a thoughtful, intelligent way, especially in 30 minutes in a room of 600 people, some with microphones
- Understand that county cultures and relationships vary greatly, try to encourage a minimum of relationships but accept existing culture may override requirements!